Alzheimer's & Dementia Services of Memphis, Inc.

Mailing Address:
3185 Hickory Hill Road
Memphis, TN 38115-2533
www.adsmemphis.org
Telephone: (901) 372-4585
Fax: (901) 554-8535

Two Locations:	
Kennedy Park Center 4585 Raleigh LaGrange (In Kennedy Park) Memphis, TN 38128-6413	Dorothy's Place 3185 Hickory Hill Road (At Knight Arnold Rd.) Memphis, TN 38115-2533

Keeping Families Together - for over 40 years!

Applicant General Information

Name: _____ Preferred Name to Be Called: _____

Address: _____

City / State / Zip Code: _____ Phone: _____

Applicant Personal Information - This information will remain confidential.

Social Security Number: XXX-XX-_____ Medicare Number: XXX-XX- _____ Birth Date:____/____/____

Age: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Applicant Preferences (Please Check)

Preferred Center: ☐Kennedy Park/Raleigh LaGrange ☐Dorothy's Place/Hickory Hill Desired # of Days/Week: _____

Preferred Days: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Any Day ☐ First Available

Primary Caregiver or Responsible Person Information

Name: _____ Relationship to Applicant: _____

Address: _____

City / State / Zip Code: _____ Home Phone: _____

Work Address:_____ Work Hours: _____

Work Phone: _____ Pager Number: _____

Mobile Phone: _____ Other Phone: _____

E-mail: _____

Is the billing address the same? ☐ Yes ☐ No (If no, please provide correct information below.)

Billing Name: _____

Billing Address: _____ City /State / Zip Code: _____

How did you find out about Alzheimer's Day Services? _____

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Applicant _____ **Caregiver** _____

Advance Directives

☐ Power of Attorney ☐ Living Will ☐ Do Not Resuscitate ☐ P.O.S.T ☐ None ☐ Other _____

Power Of Attorney's Name: _____

For office use only:

Please provide Alzheimer's and Dementia Services of Memphis, Inc. (ADS Memphis) with a copy of any that may apply.

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver listed on page 1)

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Address: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

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Applicant _____ **Caregiver** _____

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver on page 1)

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Primary Physicians - Hospital Preference

Doctor's Name: _____ Doctor's Name: _____

Specialty: _____ Specialty: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Hospital Preference: _____ Last Time Hospitalized: _____

Reason for Hospitalization: _____ Length of Stay: _____

Long-term effects: _____

Safe Return Information

Is the Applicant registered in this national program for possible wanderers? ☐ Yes ☐ No

If you answer yes, please record registration number here: _____.

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Applicant _____ **Caregiver** _____

Applicant Assessment

If you answer yes, please explain.

Has there been any recent ☐ Weight loss? ☐ Gain? ☐ No Amount: _____lbs. How Long:_____
Are there any Drug Allergies: ☐ Yes ☐ No What Drugs: _____ Type of Reaction:_____
Are there any Food Allergies: ☐ Yes ☐ No What Foods: _____ Type of Reaction:_____
Does He/She Smoke/Chew/Dip: ☐ Yes ☐ No How Much?: _____
Can the Applicant Read? ☐ Yes ☐ No
Does the Applicant Write? ☐ Yes ☐ No
Is the Applicant: ☐ Left Handed? ☐ Right Handed?

Hearing Impairment:

Right Ear: ☐ No Hearing Loss ☐ Some Hearing Loss ☐ Complete Hearing Loss ☐ Hearing Aid ☐ Refuses to Wear Aid
Left Ear: ☐ No Hearing Loss ☐ Some Hearing Loss ☐ Complete Hearing Loss ☐ Hearing Aid ☐ Refuses to Wear Aid

Visual Impairment:

Left Eye: ☐ No Impairment ☐ Cataracts ☐ Implants ☐ Other: _____
Right Eye: ☐ No Impairment ☐ Cataracts ☐ Implants ☐ Other: _____
Glasses: ☐ Reading ☐ Distance ☐ Bifocals ☐ Does not wear, explain: _____

Dentures: ☐ Yes ☐ No
Upper: ☐ Full ☐ Partial ☐ No Teeth ☐ Removable bridge ☐ No Teeth
Lower: ☐ Full ☐ Partial ☐ No Teeth ☐ Removable bridge ☐ No Teeth

Describe how well you think the applicant functions in the following areas.

Walking:

Steady on his/her feet ☐ Yes ☐ No
Without any help ☐ Yes ☐ No
With some help ☐ Yes ☐ No Explain: _____

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Supervised walking ☐ One to one assistance

Eating:

☐ Without Help ☐ Some Help_____ ☐ Needs to be prompted to eat
Please explain

Other considerations: _____

Swallowing:

Does the applicant have problems swallowing his/her food? ☐ Yes ☐ No
Does the applicant store food in his/her mouth? ☐ Yes ☐ No

Diet:

☐ Regular ☐ No Extra Sugar ☐ No Extra Salt ☐ Other Restrictions_____

Appetite:

☐ Good ☐ Poor ☐ Eats too fast

Please list food dislikes or any eating concerns:

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Applicant _____ **Caregiver** _____

Applicant Assessment (cont.)

Toileting

Bowel and Bladder:

Incontinence of Bladder: ☐ Yes ☐ No ☐ Nighttime Only

Incontinence of Bowel: ☐ Yes ☐ No ☐ Nighttime Only

Incontinence products Used in Daytime: ☐ Nothing ☐ Panty Liners ☐ Pads ☐ Adult Diapers ☐ Other: _____

Help Required: ☐ None ☐ Reminders ☐ Physical Assistance ☐ Positioning ☐ Supervision ☐ Hygiene ☐ Diapers

Any other toileting concerns? If so, please explain:

Dressing

Help Required:

☐ None ☐ Lay out clothing ☐ Supervise only ☐ Verbal cuing ☐ Physical Assistance ☐ Cooperative ☐ Resistant

Behavior (Please check ALL that apply)

Communication

☐ Difficulty communicating wants and needs
☐ Difficulty completing sentences
☐ Sentences do not make sense
☐ Difficulty naming people
☐ Difficulty expressing self Please explain: _____
☐ Has difficulty concentrating on a task or activity
☐ Takes little or no interest in activities and will not start them by self
☐ Often asks the same questions over and over again
☐ Loses or misplaces objects
☐ Has difficulty following simple directions
☐ Hoards objects
☐ Wanders away from home: # of times: _____ ☐ Wanderer's Bracelet? ☐ Medic Alert Bracelet?
☐ Cannot be left alone, must be supervised
☐ Demands constant attention and will not let you out of sight
☐ Becomes verbally abusive When: _____
☐ Becomes combative When: _____
☐ Becomes anxious When: _____
☐ Becomes agitated When: _____
☐ Becomes stubborn or uncooperative When: _____
☐ Engages in embarrassing or socially inappropriate behavior How: _____
☐ Talks to people he/she doesn't know
☐ Denies or seems unaware that anything is wrong
☐ Reports seeing or hearing things that are not there
☐ Frequently appears depressed or withdrawn
☐ Engages in behavior that is potentially dangerous to self or others What: _____

Please list any other behavior that you may be aware of.

Personality

Before onset of Illness_____ Current_____

Pattern of relating to others ☐ Outgoing ☐ Involved ☐ Social ☐ Loner

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Applicant _____ **Caregiver** _____

Applicant Assessment (cont.)

Primary Caregiver ☐ Spouse ☐ Child ☐ Other _____

Who would you say is the primary person responsible for Applicant? _____

Does primary caregiver live with Applicant? ☐ Yes ☐ No

If no, living arrangements: ☐ Lives Alone ☐ Spouse ☐ Relative ☐ Hired Caregiver ☐ Other

Is primary caregiver employed? ☐ Full time ☐ Part time ☐ Does not work ☐ Will work in future

Does the primary caregiver attend a support group? ☐ Yes ☐ No

Does or has any other family member had AD? ☐ Yes ☐ No

Family Goals for daycare ☐ Socialization ☐ Stimulation ☐ Family Relief ☐ Supervision ☐ Other: _____

Names that the Applicant most remembers: Name: _____ Relationship to Participant _____

Name: _____ Relationship to Participant _____

Applicant Interests (Current and past.)

Previous Occupation: _____ Work Place: _____

	Current	Past		Current	Past		Current	Past
Listening to Music	☐	☐	Singing	☐	☐	Playing Instrument	☐	☐
Sports	☐	☐	Games	☐	☐	Exercising	☐	☐
Knitting/Sewing	☐	☐	Drawing/Painting	☐	☐	Cooking/Baking	☐	☐
Gardening	☐	☐	Walking	☐	☐	Looking at Magazines	☐	☐
Handyman, Mr. Fixit	☐	☐	Dancing	☐	☐	Traveling	☐	☐
Pets	☐	☐	Grandchildren	☐	☐	Other	☐	☐

How does the applicant currently spend his/her day?

Name of person completing this form: (Please Print) _____

General Applicant Data – OPTIONAL – For Statistical Purposes Only

Gender: ☐ Male ☐ Female Place of Birth: _____ (City/State) Ethnic Background: _____

Year emigrated to US: _____ Primary Language Spoken: ☐ English ☐ Other: _____

Nickname: _____ Likes To Be Called: _____ Religion: _____

Age at retirement: _____ How did the applicant adjust to retirement? _____

Is the applicant a veteran? ☐ Yes ☐ No Education: ☐ 8th grade ☐ High School ☐ College ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed If widowed, how did he/she adjust? _____

What have we not asked you that you think we need to know.

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Current Medications

Please list **ALL** medications taken.

- List both PRESCRIPTION and NON-PRESCRIPTION, over the counter drugs, herbs, and natural supplements.
- In an emergency, EMT's will ask about **ALL** medications taken.

APPLICANT'S NAME: ---------- DATE: ----------

Date	Medication Name	Dose	Frequency	Reason for Taking	

*Medications taken once (1) or twice (2) a day should be taken at home.

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Alzheimer's & Dementia Services of Memphis, Inc.

These items will be discussed during the pre-enrollment visit and may be signed at that time. Signatures # 1, 2 and 3 are required for enrollment.

FINANCIAL RESPONSIBILITY (REQUIRED)

I, (please print) _____ understand that I am responsible for all
Caregiver/Responsible Party
fees and charges incurred by (please print) _____ at Alzheimer's & Dementia
"Friend"
Services of Memphis, Inc. above and beyond fees not covered by
_____ such as late fees, Drop-In extra days
"Third Party Payer"
or bathing fees.

Sign Here: # 1 Signature **Date** **CODE**

_____ _____ _____

_____
Billing Address if different than caregiver's address:

_____
City/State/Zip

_____

AUTHORIZATION FOR EMERGENCY CARE (REQUIRED)

I understand that Alzheimer's & Dementia Services of Memphis, Inc. is a social agency and that no medical services are available at the facility. I hereby authorize Alzheimer's & Dementia Services of Memphis, Inc. to have the above named "Friend" transported by ambulance for medical treatment in the event of an emergency. I agree to pay for all costs incurred. I also give permission for ADS' staff to provide emergency medical personnel with any information which will assist them in the treatment of the emergency.

Sign Here: # 2 Signature **Date**

_____ _____
Caregiver/Relative/Responsible Party

NOTICE AND AGREEMENT (REQUIRED)

The caregiver shall hold Alzheimer's & Dementia Services of Memphis, Inc. (ADS) harmless against all losses, damages, accidents or injuries to person or property of any "Friend" or family member, guest, invitee or servant of the "Friend" or caregiver caused by or resulting from or in connection with his/her/their use or occupancy of the ADS premises or things in or about the ADS premises including travel to or from ADS.

Sign Here: # 3 Signature **Date**

_____ _____

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Photo/Media/Artwork Release and Authorization

Please Print

Friend's Name: _____ Date: _____

Caregiver's Name: _____

Agency Name: Alzheimer's & Dementia Services Date: _____

I consent to and authorize my photograph being taken and my voice being recorded, along with any other audio/visual recordings or images of me by Alzheimer's and Dementia Services of Memphis, Inc. (ADS). My authorization applies to reproductions and use of my likeness, voice, artwork and first name by photographic or electronic media means, such as still or moving photographs or digital images, television, and internet, for any non-commercial use, and specifically, publicity and fundraising by ADS. I give my permission for any image and voice to be recorded and for my artwork, or reproduction, to be used in the manner described above without compensation to me or my family.

I authorize and give ADS unlimited permission to use, publish and republish my image and voice and artwork in the manner described above for all past, present, and future periods. My authorization shall continue and remain in effect until I withdraw my authorization. I have received a copy of this Authorization.

Additional Health Information Disclosed. I understand and agree that the above-described use of any photographs/recordings authorized by me may also disclose Protected Health Information, and I authorize such disclosure.

Signing of Authorization is the "Friend's" Choice: I understand that I am not required to sign this Authorization and my decision not to sign will not affect any care, payment, enrollment, or eligibility for any benefits.

Withdrawal of Authorization: If I sign this Authorization, I may revoke or withdraw the authorization at any time by giving written notice to the Executive Director of ADS at 3185 Hickory Hill Road, Memphis, TN 38115. A withdrawal of this Authorization will not prevent ADS continued use of any of the above-described records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. During recording or filming, I have the right to stop the recording/filming of me at any time.

Release of Liability: I agree that ADS, including its governing Board, agents, and employees, are released, and held harmless from legal responsibility or liability for their access to and release of my information, images, recordings, and artwork.

Re-disclosure: I understand that once the above-described information, images, recordings, and artwork are disclosed, it may no longer be protected by federal or state law.

Sign Here:

Friend AND/OR Caregiver/Relative/Responsible Party Date

I DECLINE AUTHORIZATION AT THIS TIME Date

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Physician's Statement Form

Fax return to: (901) 554-8535

DATE: _____

TO: _____

MD Fax: _____

Your Patient (Name):_____

(Address): _____

is making application to attend the Alzheimer's & Dementia Services of Memphis, Inc. program Please complete the following and return to Alzheimer's & Dementia Services of Memphis, Inc., 3185 Hickory Hill Road, Memphis, TN 38115-2533 or FAX to (901) 554-8535

Your patient cannot be enrolled until this form is returned to us:

Primary Diagnosis: _____

Secondary Diagnosis: _____
(use back if necessary)

Date of last examination: _____

I certify that _____ is free from any communicable diseases and is also able to participate in an adult day program with the following limitations:

Physical limitations: _____

Dietary limitations: _____

Allergies: _____

Physician's Name: _____

Address: _____

Phone: _____

Date: _____ Signature: _____

HEALTH RECORD RELEASE

To: _____
(Doctor, Hospital, or Health Department)

Address: _____
Address City/State Zip Code

I hereby authorize and request you to release to:

Alzheimer's & Dementia Services of Memphis, Inc.
(901) 372-4585

Location at:	**Mailing Address**	**Location at:**
Kennedy Park		**Dorothy's Place**
4585 Raleigh LaGrange	**3185 Hickory Hill Road**	**3185 Hickory Hill**
Memphis, TN 38128-6413	**Memphis, TN 38115-2533**	**Memphis, TN 38115-2533**

Name:_____
(Friend)

Address: _____
Address City/State Zip Code

Medical Records and/or other information concerning my illness and/or treatment of _____

Sign Here: _____ Date:_____
(Participant or Responsible Party)

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